

Tips for Working with Somaticizing Patients

- Patience! Patience! Patience!
- Develop a relationship with the patient and encourage patient to see only one physician.
- **Listen** to the patient's story. It takes less time than you think. Accept the patient's symptoms, and acknowledge the patient's affect.
- Hear the patient's somatic concerns as metaphors for life's pain in general. Remember that many of these patients have histories of abuse.
- Query re: home situation, family strife or recent social changes. Shift the focus of the visit to discuss these issues.
- See the patient at regular intervals, so that appointments are not tied to exacerbation of symptoms—they do not have to get worse to see you. You may keep these visits brief.
- Engage the patient in his/her care and management; examples include symptom diaries or other homework assignments.
- Do a brief physical exam focused on the organ system of complaint. Touch the patient during each visit.
- Make limited suggestions, but do not expect to fix the problem. Remember that the patient may need the symptoms.
- Avoid diagnostic tests and procedures unless clearly indicated. Tolerate your own anxiety about limiting tests.
- Call consultants yourself rather than referring the patient to them.
- Remember to assess for depression and anxiety.
- Assess daily functioning and acknowledge the patient's "maintenance of effort" as well as achievements.
- **Patience! Patience! Patience! This is a chronic condition which requires management, not cure.**

Integrating the Mind-Body Split

A Biopsychosocial Approach to Somatic Fixation

Somatic fixation is a process whereby a physician and/or a patient or family focuses exclusively and inappropriately on the somatic aspects of a complex problem (1). Somatic fixation can occur not only in hypochondriasis, somatization disorder, and psychosomatic disease, but in any illness, especially chronic illness, when there is a one-sided emphasis on the biomedical aspects of a multifaceted problem. In spite of very difficult life situations, somatically fixated patients tend not to present with anxiety, depression, or trouble coping, but with numerous physical symptoms. The number of patients in any family practice with some degree of somatic fixation is high. One study found that one-half of all medical patients had symptoms of undetermined cause (2). Another study found somatization disorder in a family practice to be not only a prevalent problem, but also an expensive and difficult one. deGruy et al. found that these patients had a 50% higher rate of office visits, 50% higher charges, charts that were close to twice as thick as the average chart, and significantly more diagnoses than matched controls (3).

The following example illustrates a common course for somatic fixation that can occur in association with a serious illness.

Although Mr. Hammer's only biomedical problem was mild hypertension, he visited his family physician, Dr. E, frequently for numerous concerns about his health. Usually his anxiety could be reduced temporarily by a brief physical exam and reassurance by Dr. E. Unfortunately during one of these visits, a prostate nodule was detected, causing Mr. Hammer to become extremely fearful and upset.

A biopsy of the nodule revealed cancer and Mr. Hammer underwent a radical prostatectomy. Immediately after surgery, he and his wife were reassured by the surgeon that he had "gotten it all!" However, when the final pathology

report came back, the surgeon explained that all the malignant cells may not have been removed, and that Mr. Hammer should receive radiation therapy. Mr. Hammer agreed, but had great difficulty dealing with the news that there might be some residual cancer. He became severely depressed and was referred to a psychiatrist who hospitalized him for one week. Mr. Hammer improved on antidepressants, and was discharged to Dr. E's care. The consulting psychiatrist felt Mr. Hammer should remain on antidepressants, but felt he was "not a good candidate for psychotherapy."

During these events Mr. Hammer's level of somatic fixation escalated dramatically. Dr. E saw him frequently, monitored his physical state carefully, and reassured him liberally. This seemed of only momentary benefit to Mr. Hammer. Mr. Hammer confessed his fears to his wife, who also reassured him, speaking from her own experience of having two episodes of breast cancer and a period of serious depression between the two episodes.

Mr. Hammer had worked all his life in construction and had retired several years before this health event. He had prided himself in being active and handy around the house. In the several years after his treatment for cancer, he became inactive, withdrawn, and preoccupied with the prospect of a recurrence of his cancer. He reported pain and discomfort in the prostate area, difficulty concentrating, and dry eyes. Every time Mr. Hammer experienced a new symptom, Dr. E evaluated him, always with negative findings. Often his surgeon also evaluated him with similar results. Dr. E was concerned about Mr. Hammer's persistent depression and tried several times to change him to a more effective antidepressant. Each time Mr. Hammer had such difficulty making the change and reported so many side effects that his physician maintained him on the original medication. Several years postsurgery, Mr. Hammer was no longer severely depressed but he was quite markedly somatically fixated.

Because of the seriousness of Mr. Hammer's disease, he and his care providers had difficulty pursuing the psychosocial aspects of his adjustment. Mr. Hammer had always been action-oriented rather than emotional or verbally oriented, so he had little to draw on from his previous life to help him adjust to his new status. His father, in fact, had a serious illness late in mid-life and had not been able to make a healthy adjustment. He had become reclusive and very difficult to deal with until his death some years later. In addition to Mr. Hammer's somatic fixation, Dr. E struggled with her own tendency to panic over her patient's symptoms. She was very fond of Mr. Hammer and felt in some way responsible for not picking up the cancer earlier, so that when he requested more tests to evaluate his symptoms she almost always concurred, with or without strong medical evidence to support the testing.

Why is somatic fixation, like that of Mr. Hammer, so widespread and so difficult to manage? There are a number of individual, family, and cultural factors that support the maintenance of somatic symptoms.

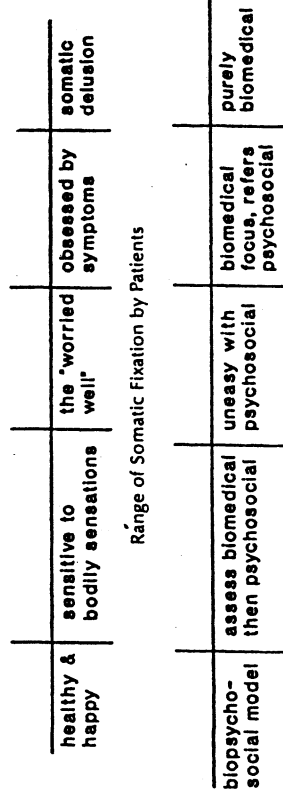
- **Individual factors.** The first relevant individual factor is rooted in the normal human experience of physical sensations. Kellner and Sheffield found that 60–80% of healthy individuals experience some somatic symptoms in any one week (4). If even a small proportion of these people saw their physician, our offices would be flooded with

patients. Also, individuals' perceptions of a symptom are quite variable. It is well documented that the same amount of tissue pathology produces varying degrees of functional impairment and subjective distress in different individuals (5). Mr. Hammer, in the preceding case example, was very sensitive to any physical sensation in his body (and equally insensitive to emotional cues). After his surgery, he experienced a much greater degree of impairment and distress than most patients with similar disease and treatment.

- **Familial factors.** Many family factors can potentially support or reinforce somatic fixation. A subgroup of all people are raised in an environment where they receive some attention for physical pain but no attention for emotional pain. If families operate on a continuum from full encouragement and acceptance of emotional and physical experience to complete lack of acceptance of one or both, these repressed families condition children to experience any need or problem as physical. Physical symptoms become their language for a range of experiences, from physical to emotional. These patients may learn, as Barsky described, to amplify their bodily symptoms in an attempt to get their needs met (6). In keeping with this explanation, Katon found that chronic, severe somatizers also tend to have a developmental history of gross neglect and abuse as well as a family history of relatives using somatization or pain behavior as a way of coping or solving problems (7). Mr. Hammer came from a family in which his father was a somatizer. His family was emotionally unexpressive and communicated through physical symptoms. While he did not report a history of physical abuse, his parents did seem to be stressed and incapable of meeting many of his emotional needs.

- **Cultural factors.** In addition to the individual and family contributions to the development and maintenance of somatic fixation, our culture contributes to the problem by remaining rooted in the Cartesian notion of a mind-body dichotomy. Our language and much of our belief systems encourage patients like Mr. Hammer to conceptualize the physical as apart from and unrelated to the emotional. The notion that a physical symptom must have a primarily organic cause, or that an emotional feeling is determined primarily by some psychological experience, is well-accepted in our society. The idea that mind and body are an integrated, related, communicating whole has only recently, and tentatively, been considered by the wider society. Medicine itself has focused particularly on biomedicine in the twentieth century, in part because of the many scientific and technological advances that have occurred relatively recently. These advances make it that much more seductive to conclude that biomedicine is medicine, rather than it being one very important component of the diagnosis and treatment of a patient.

However, an alternative paradigm has emerged. The biopsychosocial approach is the medical model that operationalizes the systemic approach



Range of Somatic Fixation by Patients

FIGURE 16.1.

to medicine; it is essential to the management and treatment of somatic fixation. Every physical symptom has some biologic, some psychologic, and often some social component to it. A physician needs to be able to address each of these areas in a balanced and integrated way, without fixating inappropriately on any one component of the symptom.

Figure 16.1 illustrates the range of somatic fixation possible for patients and for physicians. Patients may range from being comfortable with health and physical and emotional experience on one end of the continuum to amplifying symptoms and worrying over illness or expressing somatic delusions at the other extreme. Physicians may also express a range of behavior with regard to somatic fixation: from utilizing an integrated, biopsychosocial approach, to treating the biomedical and psychosocial separately and referring out most psychosocial problems, to the extreme position of perceiving and treating only biomedical problems.

This chapter will advocate for a biopsychosocial approach to somatic fixation, first describing the vicious cycle that physicians and patients can be drawn into and then elucidating principles of a successful biopsychosocial approach to the management and treatment of these problems.

The Battle of the Health Belief Systems

Somatic fixation can also be described as an interactional process that occurs when the health belief system of a patient and/or family does not match that of a physician. For example, in Mr. Hammer's case, postsurgery Dr. E believed that Mr. Hammer's symptoms were a result of his fear, depression, and ongoing sensitivity to bodily cues. Mr. Hammer, however, believed these symptoms indicated a recurrence of his cancer. These differing diagnoses made it difficult for the two individuals to understand each other or communicate without conflict.

Mr. and Mrs. Hunter were well known to Dr. B as patients who were extremely sensitive to physical symptoms and tended to worry about illness and disease. This couple had many strengths: they were devoted to parenting their three sons, they enjoyed their work, and they were committed to their church and their community. However, they were unusually conscious of their bodily cues. They and their sons each had occasional flu, colds, and headaches, which would send them to the office requesting medicine for benign diagnoses. On each visit Dr. B would treat the problem, reassure them, and check into other life events that might be stressing the family at the time. Until the last few years, this approach was effective. At that time, Mr. and Mrs. Hunter lost a second daughter to congenital heart defects soon after birth. Within a year, Mr. and Mrs. Hunter were making at least monthly visits to Dr. B with multiple somatic complaints. Reassurance and benign diagnoses no longer were effective in decreasing their anxiety.

Treating somatically fixated patients such as the Hunters requires careful and explicit attention to principles of biopsychosocial medicine:

1. **From the beginning, evaluate biomedical and psychosocial elements of the problem concurrently.** The physician can avoid operationalizing the mind-body split by mixing biomedical and psychosocial questions in the interview, a technique suggested by Doherty and Baird for all primary care interviewing (8). In particular, it is important to avoid working up the patient medically, finding nothing, then turning to a psychosocial evaluation. This dichotomy mimics the patient's belief that the two are separate, unrelated processes. It relegates the psychosocial to a position of lesser importance and leads to the common patient accusation: "You think this is all in my head." Interspersing questions about disease signs and symptoms with questions about recent stressful life events avoids this problem.

Try to do a balanced, reasonable work-up, neither overusing tests nor avoiding the biological aspects of the symptoms.

2. **Solicit the patient's symptoms, but do not let the symptoms run the interview.** It is important to respect the patient's somatic defenses; if these patients were able to tolerate direct expressions of emotion or distress, they would not have to somatize. By soliciting symptoms, the provider is able to speak these patients' language, enter their belief system, and metaphorically gain access to and validate their emotional experience. It is especially important to structure these interviews in such a way that the patient feels his or her concerns are heard and yet does not dominate the interview with long, rambling descriptions of pain and symptomatology. Several techniques can keep the physician active in the interview and prevent the patient from monologuing:

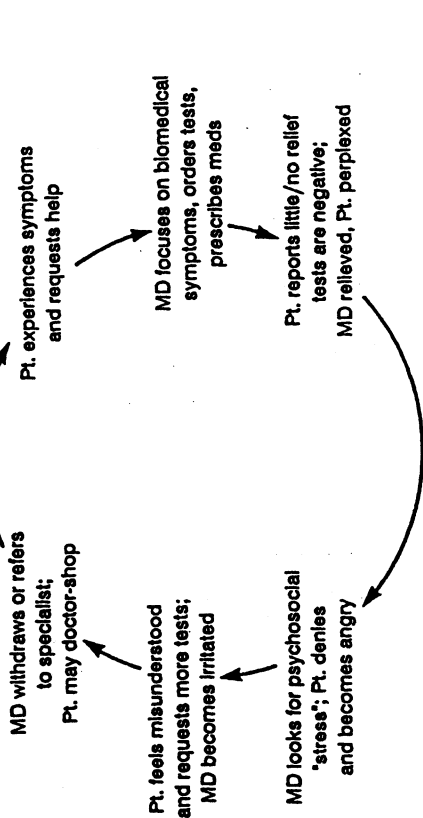


FIGURE 16.2. Somentically fixated physician-patient interaction.

Figure 16.2 illustrates the vicious cycle that can occur in interactions between a somatically fixated patient and a physician who hold differing health belief systems. This cycle can begin when a patient experiences symptoms and seeks help from a medical provider. If we assume that the physician does not routinely use a biopsychosocial approach, that physician might review the patient's symptoms, listen sympathetically, and perhaps order some tests and prescribe some medication. In the next interaction, the tests may come back equivocal or negative. The physician then experiences relief, but notices that the patient is perplexed. With no biomedical answers, the physician turns to a psychosocial evaluation. The patient may then become angry and deny that the problem is "in my head." At this point the patient feels misunderstood and requests more tests, leading the physician to become irritated. Then, the physician may withdraw from the patient and/or refer out to a medical specialist, or the patient may drop out of the practice and begin a process of doctor-shopping. Either outcome sets the cycle into motion again as the patient presents his or her symptoms to a new physician. The lack of a shared belief system can result in a vicious cycle in which both physician and patient are locked into a battle over the patient's somatic fixation. The way out of the struggle involves adopting an integrated biopsychosocial approach from the beginning of the interaction with the patient. From a broad perspective, treatment consists of slowly educating and demonstrating to the patient the interconnections between biological and psychological systems. At the end of a course of treatment physician and patient are closer to sharing a common health belief system that recognizes this interdependency.

purely biomedical perspective. These attitudes on the part of the physician also underline the importance of the patient's contribution to the diagnosis and treatment of these difficult problems.

4. See the patient at regular intervals, not dictated by symptom occurrence or intensification (9), and discourage visits to other health care providers, except upon specific referral. Regular and frequent appointments with the primary care physician are important to disconnect the patient's experience of crisis and symptoms resulting in attention and care. Instead the attention and care is given liberally without relation to acute symptoms. It is also important that these patients be routed through the primary care physician for all acute and chronic complaints, avoiding Emergency Department visits and referrals to medical specialists unless clearly indicated. Multiple work-ups and dispersal of these patients' care tend to reinforce biomedical fixation. When biomedical referral is necessary, it is important to talk with the consultant beforehand and be specific about the referral question.

Dr. B was careful in the early stages to share his concern and confusion with the Hunters over their symptoms. He agreed with them that they deserved to have a "cure," but stated that an easy solution did not seem possible in their case. They would have to work together to manage these difficult and mysterious problems. Dr. B underlined his accessibility to the Hunters, telling them to see him every several weeks for the next few months until they began to function a little better. He encouraged them to bring any acute or chronic complaints to him rather than elsewhere. He told them other services, such as the Emergency Room or even other physicians unfamiliar with their cases, were likely to be ineffective with their problems and cost them more money because they would have to start from ground zero with each new evaluation. The Hunters agreed they did not wish more aggravation than they already had.

5. Elicit the patient and family's diagnoses of the problem. It is important to understand the meaning of the symptom to the patient, and the patients' explanations for the problem will often lead to what they expect from treatment. Following up on these concerns is important to develop a constructive relationship in which these patients feel heard. Over time, it is important to work toward mutually acceptable explanations for the symptoms.

6. Elicit any recent stressful life events, life cycle challenges, or unresolved family problems. Of particular importance to somatic fixation are problems such as early abuse or deprivation, unresolved grief, alcohol or drug abuse, and workaholism and other forms of overfunctioning. These questions may be best addressed during a family conference.

Both Mr. and Mrs. Hunter initially worried that they had cancer. Mr. Hunter later reported that a friend had suggested perhaps he had AIDS, and Mrs. Hunter continually worried that she had some serious "female problems."

• S and reflect or ask a question after each sentence or two by the patient

• Interrupt if necessary

• Assume a curious or perplexed posture rather than a frustrated, intimidated, or weary posture

• Unusual symptoms call for unusual diagnostic procedures—ask the patient to diagram symptoms, measure their length or intensity, and be active in the diagnostic process

The physician must be able to persist through what is typically a difficult early period of evaluation and heavy symptom focus by the patient. Requesting a symptom diary, especially one that includes both biomedical and psychosocial information about symptoms, can be useful in allowing the patient their concern about their symptoms, involving them in the diagnostic process, and providing information for the patient and the physician about the symptoms. The diary may be requested by explaining: "Your body is trying to signal us about something important. Unfortunately, we do not understand its signals just yet. We must work together to try and discover what it is telling us."

Early in treatment with the Hunters, Dr. B tried but had difficulty discussing the death of the couple's two daughters. Attempts to broach psychosocial issues were met with Mr. Hunter complaining, for example, that his right testicle was cold or that his semen was discolored. Mrs. Hunter usually accompanied her husband to see Dr. B and had her own litany of physical complaints. They included abdominal pain, ear pain, headaches, and unusual vaginal discharge. Mr. and Mrs. Hunter tended to be symptomatic simultaneously. Attention or attempted treatment of one inevitably led to symptoms and the need for treatment in the other. It seemed as if these patients may have had a chlamydia infection at some time, though no evidence existed of such an infection by the time of the consultations. Rather than increase the patient's resistance by focusing totally on the emotional, Dr. B carefully interspersed his psychosocial questions with more biomedical questions about Mr. Hunter's symptoms. Early in treatment, Mr. Hunter rarely answered the questions about stress directly, but continued to complain of various symptoms, including pains that shot up through his chest, being awakened by the sound of bubbles popping in his lungs, and being generally lethargic and unable to work. Dr. B asked both members of the couple to keep a symptom diary, and the patients brought in pages of symptoms and complaints, reporting little about their emotional states.

3. Develop a relationship with the patient that is collaborative. It is important with these patients to avoid an authoritarian position and any implication to the patient (or ourselves) that a "magic bullet" exists that would relieve them of their symptoms. It may be useful to describe these symptoms as mysterious and scientifically baffling; this approach underscores the physician's inability to treat these problems from a

some other life-threatening illness. Testing and physical exams revealed no medical evidence for any of these concerns. Over 2-3 months of visits, these patients slowly began discussing the stressful events in their family life, which included long work hours and alcohol abuse by Mr. Hunter, and the difficulties that had occurred after their babies' deaths. Both provider and patients eventually agreed their symptoms were likely a result of some mixture of an early chlamydia infection, depression and unresolved grief after their daughters' deaths, alcohol abuse, and marital stress.

7. Invite the family to participate early in treatment. Including the family is important because symptoms can be maintained or intensified because they come to have meaning to significant others. Sometimes symptoms have interpersonal effects such as eliciting expressions of concern or sympathy and affording relief from responsibilities or work. At a family conference, it is useful to:

- a. request each person's observations, diagnoses, and opinions about the illness and the treatment
- b. listen for how the illness may have changed the typical roles or balance of power in the family
- c. try to understand any marital and/or transgenerational meaning for the symptom by asking, "Has anyone else in the family had an illness that in any way resembles this one?"
- d. ask what each person is doing to help the patient with the illness
- e. ask how family life would be different if the patient's symptoms disappeared or improved
- f. develop a treatment plan that the group can accept and request each person's help in its implementation.

Interviewing Mr. and Mrs. Hunter together was both efficient and informative. Both Mr. and Mrs. Hunter reported that their illness had brought them closer together. Mr. Hunter had stopped working, the couple spent all their time together, and their fears of dying helped them readjust their priorities and realize how much they meant to each other. In fact, as Mr. and Mrs. Hunter improved, both worried that complete symptom relief would result in renewed marital stress or at least more distance between them, and in another episode of alcohol abuse by Mr. Hunter.

A few months after their treatment began, Dr. B invited both spouses' parents in to share their concerns about their children's illnesses. An in-depth genogram taken in that session revealed that both Mr. and Mrs. Hunter's fathers were alcoholic and their mothers both had chronic medical problems that appeared to fit a pattern of somatic fixation. Both families agreed they had much in common. In this session, they arrived at a plan for the couple's parents to help with the grandchildren so the couple might return to work as their functioning improved.

8. Solicit and constantly return to the patient and family's strengths and areas of competence. Patients with severe somatic fix-

ation often have a history of deprivation or abuse; sup- is an important part of their treatment. Also, it is easier to build on strengths than to rectify deficiencies.

9. Avoid psychosocial fixation; continue with an integrated approach. In addition to the psychological aspects of somatic fixation, there are frequently biomedical components. Also, somatically fixated patients get sick at times, so remain fully alert for somatic signs of serious disease.

An ongoing integrated approach is both scientifically sound and an art form in itself. The best interventions with somatically fixated patients are those that combine the biomedical and the psychosocial, i.e., biomedical interventions that make psychological sense and psychological interventions that make biomedical sense. Similarly, explanations about scarring, stress, or a depressed immune system are attempts at integrating these two aspects of the illness.

With the Hunters, continued focus on their devotion to each other and their commitment to good parenting of their children helped to support and balance the treatment. As an outgrowth of the focus on their good parenting, discussion of their daughters' deaths became somewhat easier. One very important intervention came when Dr. B reviewed the Hunters' daughters' autopsy report with them. While the couple had consistently had difficulty speaking directly about their sorrow, this medical approach facilitated their grieving and allowed them to ask questions that had heretofore not been asked.

10. Find a way to enjoy somatically fixated cases. These cases are traditionally frustrating and time-consuming for physicians, as demonstrated by the vicious cycle described in Fig. 16.2. These patients and their families often feel frustrated, angry at the medical establishment, and discouraged about the patients' illnesses. Finding a way to enjoy these cases allows one to stay connected to these difficult patients, and it prevents physician burnout. Cognitive and emotional strategies for enjoying these patients and their families include the following:

- a. Listen to the patient's symptoms as metaphors for their larger problems.
- b. Monitor both the patient's and your own discomfort with uncertainty. Somatic fixation offers many opportunities to rediscover that which we understand or have control over and that which we do not.
- c. Discuss the case with a physician colleague, or invite that person to consult. Frustration with any patient or family is often dissipated when some respected colleague can offer support and another point of view.
- d. Refer or collaborate closely with a family therapist or other mental health consultant. Many severe cases of somatic fixation require in-depth experience and expertise in both the biomedical and the psychosocial areas; collaboration offers an avenue of support and shared

responsibility for difficult cases; also, collaboration around this disorder can be the most cost-effective approach. Smith, Monson, and Ray, in a randomized controlled study, found that a psychiatric consultation coupled with recommendations for the primary care physician of patients with somatization disorder reduced these patients' medical costs by 53% (10). (See Chapter 22 for more on collaborating and referring to mental health professionals.)

While Dr. B felt he had made considerable progress in helping Mr. and Mrs. Hunter, he remained concerned about lingering grief issues as well as continued signs of marital distress. As in some cases of severe somatic fixation, Dr. B decided that he needed to consult with a family therapist to provide effective biopsychosocial care to this couple.

The therapist, Dr. T, and the physician, Dr. B, held a joint meeting with the couple for Dr. B to introduce Dr. T, make his referral, coordinate treatment with the couple, and lend his support to the new endeavor. Dr. B and Dr. T then discussed the session and developed a joint treatment plan. Dr. T met with the couple ten times over a nine month period. Several times over that period, the physician and the therapist met together with the patients. Dr. T was able to take the time to provide Mr. Hunter with the support he needed to discuss his daughters' deaths. In one of the early joint sessions, Mr. and Mrs. Hunter stated they had grown apart during the year after their daughters' deaths and Mr. Hunter revealed that he had increased his drinking behavior and had had an affair during this time. Mr. Hunter clearly felt very guilty about this experience. Between this issue and the death of their daughters, it became clear why many of their symptoms were either focused on their genitals or were related to pregnancy and reproduction in some way. As these issues were aired, Dr. B and Dr. T recognized the couple's commitment to each other, supported them each as individuals, and simultaneously dealt with their ongoing biomedical concerns. While Dr. T usually conducted the interviews around emotionally sensitive issues such as the affair or the couple's sex life, Dr. B provided support, checked into symptoms that seemed new or concerning, and provided some creative interventions such as reviewing the daughters' autopsy reports with the couple as a way of facilitating their grief work.

11. Judge progress in these patients by monitoring changes in their level of functioning rather than in their symptoms. Symptom-free living (i.e., a "cure") is unlikely in these patients. More realistic goals involve a decrease in symptoms and an increase in functioning in areas such as work and family relationships.

12. Terminate the intense phase of treatment slowly. It is always useful with these patients to restrain them from too-rapid improvement in their symptoms. If the physician keeps his or her expectations low, the patient is free to move at his or her own pace. When some improvement has occurred, it is helpful to wonder aloud what problems might emerge if the patient were to recover completely. In addition to a restrained, cautious approach to treatment, the physician may also realistically predict relapses as improvement occurs. These predictions prevent dis-

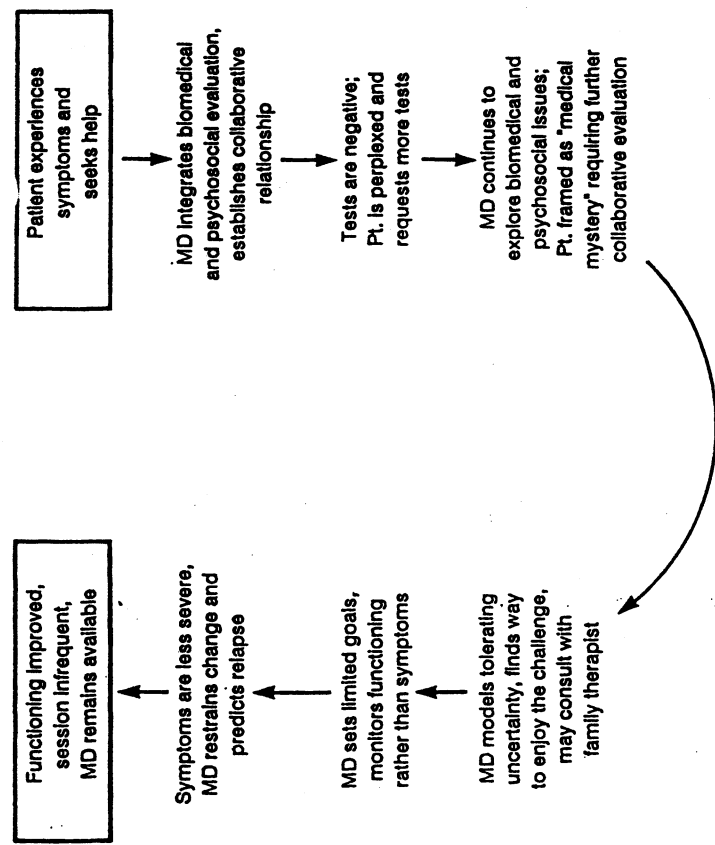


FIGURE 16.3. A biopsychosocial approach to somatic fixation.

appointment and make the typical flare-ups in symptoms part of the course of recovery.

With an increase in the patient's general level of functioning and a decrease in the incapacitating nature of the symptoms, it is useful to slowly lengthen the time between office visits. However, for the success of this process, it is crucial that the patient feel the physician is available to him or her regardless of symptom states.

By the end of nine months, Drs. B and T and the patients agreed that Dr. T no longer needed to meet with the couple. Mr. and Mrs. Hunter were not symptom-free, but the severity and frequency of their symptoms had diminished. Mr. Hunter was now working again, and Mrs. Hunter had a job for the first time since before her pregnancies. The couple reported their commitment to each other and their family was strong. Dr. B continued to see his patients, though less frequently, and Dr. T remained available for consultation if needed.

Figure 16.3 summarizes the biopsychosocial approach to somatic fixation. With this approach, the physician addresses a patient's complaints with an integrated biomedical and psychosocial evaluation from the beginning. The physician also solicits help from family members early

in the process. When the tests are equivocal or negative, patient, family, and the physician may be perplexed, and a collaborative relationship is established to manage the patient's mysterious symptoms. Of great importance is the message that the physician does not fully understand the symptoms, does not have a quick answer or pill that will solve the problem, and is able to tolerate the uncertainty while continuing to work up the various aspects of the patient's problem. At this point, the physician may or may not consult with a medical colleague or a family therapist to share in the evaluation. In either case, the physician should set limited, concrete goals for treatment and measure outcome by monitoring the patient's functioning in areas of work, family, and personal life rather than only the patient's symptom picture. As functioning improves and symptoms become less severe, the physician is cautious about a cure and predicts the inevitable relapse in the patient's symptomatology. When patient functioning has improved adequately, the patient and physician agree to make sessions less frequent. However, the physician gives a clear message that he or she will continue to remain available to the patient and the family.

This biopsychosocial approach to the management and treatment of somatic fixation offers physician, patient, and family a way out of the vicious cycle that can develop around this problem. Not only can it offer an effective alternative for treatment, but it can also provide the physician with a vehicle to enjoy working with this problem that is so often experienced as difficult and frustrating.

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PROTOCOL

Twelve Principles for a Biopsychosocial Approach to Somatic Fixation

1. From the beginning, evaluate each element of the problem.
 - a. Begin by interspersing biomedical and psychosocial questions in the interview.
 - b. Do a balanced, reasonable work-up, neither overusing tests nor avoiding the biological aspects of the symptoms.
2. Solicit the patient's symptoms, but do not let the symptoms run the interview.
 - a. Reflect or ask a question after each sentence or two by the patient.
 - b. Interrupt if necessary.
 - c. Assume a curious or perplexed posture rather than a frustrated, intimidated, or weary posture with unusual symptoms, use unusual diagnostic procedures that allow you to remain active, such as measuring the length or intensity of symptoms.
 - d. Keep the patient active in the diagnostic process—for example, request a symptom diary including both biomedical and psychosocial information about symptoms.
3. Develop a relationship with the patient that is collaborative.
 - a. Avoid taking a traditional, authoritarian position or promising any easy answers to the patient's problems.
 - b. Consider framing the patient's symptoms as mysterious and scientifically baffling, requiring the patient and physician to work together to manage the problem.
4. See the patient at regular intervals and discourage visits to other health providers, except on specific referral.
 - a. See patients at regular, frequent intervals, not dictated by symptom occurrence or intensification.
 - b. Route all acute and chronic patient complaints through the primary care physician.
 - c. Have patients avoid Emergency Department visits, medical specialists, and inpatient treatment, unless specifically recommended by the primary care physician.
 - d. When referral is indicated, be sure to talk with the consultant beforehand and be specific about the referral question.
5. Elicit the patient and family's diagnoses of the problem.
 - a. Explore the meaning of the symptom to the patient.
 - b. Given their diagnoses, what treatment do they expect will be useful?
 - c. Work toward mutually acceptable diagnoses or explanations for the symptoms.
6. Elicit any recent stressful life events, life cycle challenges, or unresolved family problems—look especially for:

- a. A history of early abuse deprivation.
 - b. Unresolved grief.
 - c. Alcohol or drug abuse, workaholism or other forms of overfunctioning.
7. Invite the family to participate in the process early in treatment.
 - a. Request each person's observations, diagnoses, and opinions about the illness and the treatment.
 - b. Listen for how the illness may have changed the typical roles or balance of power in the family.
 - c. Try to understand any marital and/or transgenerational meaning for the symptom by asking: "Has anyone else in the family had an illness that in any way resembles this one?"
 - d. Ask what each person is doing to help the patient with the illness.
 - e. Ask how family life would be different if the patient was asymptomatic.
 - f. Develop a treatment plan that the group can accept and request each person's help in its implementation.
 8. Solicit and constantly return to the patient's and family's strengths and areas of competence.
 9. Avoid psychosocial fixation; continue with an integrated approach.
 - a. Use interventions that combine the biomedical and the psychosocial.
 - b. Use biomedical explanations that also have psychosocial meanings, such as stress, scarring, or depressed immune system.
 10. Find a way to enjoy somatically fixated patients.
 - a. Listen to the patient's symptoms as metaphors for their larger problems.
 - b. Monitor both the patient's and your own discomfort with uncertainty.
 - c. Discuss the case with a physician colleague or invite that person to consult.
 - d. Refer or collaborate closely with a family therapist or other mental health consultant.
 11. Judge progress in these patients by monitoring changes in their level of functioning rather than in their symptoms.
 12. Terminate the intense phase of treatment slowly.
 - a. Restrain patients from too-rapid improvement.
 - b. Keep your own expectations low; set small, realistic goals.
 - c. With some improvement ask, what problems might emerge if the patient were to recover completely?
 - d. Predict relapses.
 - e. Slowly lengthen the time between office visits when the patient experiences an increase in general level of functioning and a decrease in the incapacitating nature of the symptoms.
 - f. Remain available to the patient.

Mobilizing Treating Depression

Depression is among the most common primary care. A majority of all primary care and depression heads 27% of patients coming to a primary care none of them indicated that depression. Because somatic complaints mask depression be overlooked or missed.

While some primary care patients depressive illness, the majority identify an adjustment reaction due to situational discord, the birth of a child, job change, major depressive disorder or another most important task is to identify available resources to provide appropriate change.

In this chapter we will focus on integrating individual, interpersonal, the identification, assessment and

An Interactional Approach

Strong evidence exists that interpersonal precipitants of depressive episodes and an episode will be resolved (3). In many events precede the onset of depression the view that depressive symptoms "tension" (5).

Somatoform Disorders

The common feature of the Somatoform Disorders is the presence of physical symptoms that suggest a general medical condition (hence, the term *somatoform*) and are not fully explained by a general medical condition, by the direct effects of a substance, or by another mental disorder (e.g., Panic Disorder). The symptoms must cause clinically significant distress or impairment in social, occupational, or other areas of functioning. In contrast to Factitious Disorders and Malingering, the physical symptoms are not intentional (i.e., under voluntary control). Somatoform Disorders differ from Psychological Factors Affecting Medical Condition in that there is no diagnosable general medical condition to fully account for the physical symptoms. The grouping of these disorders in a single section is based on clinical utility (i.e., the need to exclude occult general medical conditions or substance-induced etiologies for the bodily symptoms) rather than on assumptions regarding shared etiology or mechanism. These disorders are often encountered in general medical settings.

The following Somatoform Disorders are included in this section:

Somatization Disorder (historically referred to as hysteria or Briquet's syndrome) is a polysymptomatic disorder that begins before age 30 years, extends over a period of years, and is characterized by a combination of pain, gastrointestinal, sexual, and pseudoneurological symptoms.

Undifferentiated Somatoform Disorder is characterized by unexplained physical complaints, lasting at least 6 months, that are below the threshold for a diagnosis of Somatization Disorder.

Conversion Disorder involves unexplained symptoms or deficits affecting voluntary motor or sensory function that suggest a neurological or other general medical condition. Psychological factors are judged to be associated with the symptoms or deficits.

Pain Disorder is characterized by pain as the predominant focus of clinical attention. In addition, psychological factors are judged to have an important role in its onset, severity, exacerbation, or maintenance.

Hypochondriasis is the preoccupation with the fear of having, or the idea that one has, a serious disease based on the person's misinterpretation of bodily symptoms or bodily functions.

Body Dysmorphic Disorder is the preoccupation with an imagined or exaggerated defect in physical appearance.

Somatoform Disorder Not Otherwise Specified is included for coding disorders with somatoform symptoms that do not meet the criteria for any of the specific Somatoform Disorders.

300.81 Somatization Disorder

Diagnostic Features

The essential feature of Somatization Disorder is a pattern of recurring, multiple, clinically significant somatic complaints. A somatic complaint is considered to be clinically significant if it results in medical treatment (e.g., the taking of medication) or causes significant impairment in social, occupational, or other important areas of functioning. The somatic complaints must begin before age 30 years and occur over a period of several years (Criterion A). The multiple somatic complaints cannot be fully explained by any known general medical condition or the direct effects of a substance. If they occur in the presence of a general medical condition, the physical complaints or resulting social or occupational impairment are in excess of what would be expected from the history, physical examination, or laboratory tests (Criterion C). There must be a history of pain related to at least four different sites (e.g., head, abdomen, back, joints, extremities, chest, rectum) or functions (e.g., menstruation, sexual intercourse, urination) (Criterion B1). There also must be a history of at least two gastrointestinal symptoms other than pain (Criterion B2). Most individuals with the disorder describe the presence of nausea and abdominal bloating. Vomiting, diarrhea, and food intolerance are less common. Gastrointestinal complaints often lead to frequent X-ray examinations and can result in abdominal surgery that in retrospect was unnecessary. There must be a history of at least one sexual or reproductive symptom other than pain (Criterion B3). In women this may consist of irregular menses, menorrhagia, or vomiting throughout pregnancy. In men, there may be symptoms such as erectile or ejaculatory dysfunction. Both women and men may be subject to sexual indifference. Finally, there must also be a history of at least one symptom, other than pain, that suggests a neurological condition (conversion symptoms such as impaired coordination or balance, paralysis or localized weakness, difficulty swallowing or lump in throat, aphonia, urinary retention, hallucinations, loss of touch or pain sensation, double vision, blindness, deafness, or seizures; dissociative symptoms such as amnesia; or loss of consciousness other than fainting) (Criterion B4). The symptoms in each of the groups have been listed in the approximate order of their reported frequency. Finally, the unexplained symptoms in Somatization Disorder are not intentionally feigned or produced (as in Factitious Disorder or Malingering) (Criterion D).

Associated Features and Disorders

Associated descriptive features and mental disorders. Individuals with Somatization Disorder usually describe their complaints in colorful, exaggerated terms, but specific factual information is often lacking. They are often inconsistent historians, so that a checklist approach to diagnostic interviewing may be less effective than a thorough review of medical treatments and hospitalizations to document a pattern of frequent somatic complaints. They often seek treatment from several physicians concurrently, which may lead to complicated and sometimes hazardous combinations of treatments. Prominent anxiety symptoms and depressed mood are very common and may be the reason for being seen in mental health settings. There may be impulsive and antisocial behavior, suicide threats and attempts, and marital discord. The lives of these individuals—particularly those with associated Personality Disorders, are often as chaotic and complicated as their medical histories. Frequent use of medications may lead

effects and Substance-Related Disorders. These individuals commonly undergo numerous medical examinations, diagnostic procedures, surgeries, and hospitalizations, which expose the person to an increased risk of morbidity associated with these procedures. Major Depressive Disorder, Panic Disorder, and Substance-Related Disorders are frequently associated with Somatization Disorder. Histrionic, Borderline, and Antisocial Personality Disorders are the most frequently associated Personality Disorders.

Associated laboratory findings. Laboratory test results are remarkable for the absence of findings to support the subjective complaints.

Associated physical examination findings and general medical conditions. Physical examination is remarkable for the absence of objective findings to fully explain the many subjective complaints of individuals with Somatization Disorder. These individuals may be diagnosed with so-called functional disorders (e.g., irritable bowel syndrome). However, because these syndromes are as yet without established objective signs or specific laboratory findings, their symptoms may count toward a diagnosis of Somatization Disorder.

Specific Culture and Gender Features

The type and frequency of somatic symptoms may differ across cultures. For example, burning hands and feet or the nondelusional experience of worms in the head or ants crawling under the skin represent pseudoneurological symptoms that are more common in Africa and South Asia than in North America. Symptoms related to male reproductive function may be more prevalent in cultures in which there is widespread concern about semen loss (e.g., *dbat* syndrome in India). Accordingly, the symptom reviews should be adjusted to the culture. The symptoms listed in this manual are examples that have been found most diagnostic in the United States. It should be noted that the order of frequency was derived from studies done in the United States.

Somatization Disorder occurs only rarely in men in the United States, but the higher reported frequency in Greek and Puerto Rican men suggests that cultural factors may influence the sex ratio.

Prevalence

Studies have reported widely variable lifetime prevalence rates of Somatization Disorder, ranging from 0.2% to 2% among women and less than 0.2% in men. Differences in rates may depend on whether the interviewer is a physician, on the method of assessment, and on the demographic variables in the samples studied. When nonphysician interviewers are used, Somatization Disorder is much less frequently diagnosed.

Course

Somatization Disorder is a chronic but fluctuating disorder that rarely remits completely. A year seldom passes without the individual seeking some medical attention prompted by unexplained somatic complaints. Diagnostic criteria are typically met before age 25 years, but initial symptoms are often present by adolescence. Menstrual difficulties may be one of the earliest symptoms in women. Sexual symptoms are often associated with marital discord.

Familial Pattern

Somatization Disorder is observed in 10%–20% of female first-degree biological relatives of women with Somatization Disorder. The male relatives of women with this disorder show an increased risk of Antisocial Personality Disorder and Substance-Related Disorders. Adoption studies indicate that both genetic and environmental factors contribute to the risk for Antisocial Personality Disorder, Substance-Related Disorders, and Somatization Disorder. Having a biological or adoptive parent with any of these disorders increases the risk of developing either Antisocial Personality Disorder, a Substance-Related Disorder, or Somatization Disorder.

Differential Diagnosis

The symptom picture encountered in Somatization Disorder is frequently nonspecific and can overlap with a multitude of **general medical conditions**. Three features that suggest a diagnosis of Somatization Disorder rather than a general medical condition include 1) involvement of multiple organ systems, 2) early onset and chronic course without development of physical signs or structural abnormalities, and 3) absence of laboratory abnormalities that are characteristic of the suggested general medical condition. It is still necessary to rule out general medical conditions that are characterized by vague, multiple, and confusing somatic symptoms (e.g., hyperparathyroidism, acute intermittent porphyria, multiple sclerosis, systemic lupus erythematosus). Moreover, Somatization Disorder does not protect individuals from having other independent general medical conditions. Objective findings should be evaluated without undue reliance on subjective complaints. The onset of multiple physical symptoms late in life is almost always due to a general medical condition.

Schizophrenia with multiple somatic delusions needs to be differentiated from the nondelusional somatic complaints of individuals with Somatization Disorder. In rare instances, individuals with Somatization Disorder also have Schizophrenia, in which case both diagnoses should be noted. Furthermore, hallucinations can occur as pseudoneurological symptoms and must be distinguished from the typical hallucinations seen in Schizophrenia (see p. 275).

It can be very difficult to distinguish between **Anxiety Disorders** and Somatization Disorder. In **Panic Disorder**, multiple somatic symptoms are also present, but these occur primarily during Panic Attacks. However, Panic Disorder may coexist with Somatization Disorder; when the somatic symptoms occur at times other than during Panic Attacks, both diagnoses may be made. Individuals with **Generalized Anxiety Disorder** may have a multitude of physical complaints associated with their generalized anxiety, but the focus of the anxiety and worry is not limited to the physical complaints. Individuals with **Mood Disorders**, particularly **Depressive Disorders**, may present with somatic complaints, most commonly headache, gastrointestinal disturbances, or unexplained pain. Individuals with Somatization Disorder have physical complaints recurrently throughout most of their lives, regardless of their current mood state, whereas physical complaints in Depressive Disorders are limited to episodes of depressed mood. Individuals with Somatization Disorder also often present with depressive complaints. If criteria are met for both Somatization Disorder and a Mood Disorder, both may be diagnosed.

By definition, all individuals with Somatization Disorder have a history of pain symptoms, sexual symptoms, and conversion or dissociative symptoms. Therefore, if these symptoms occur exclusively during the course of Somatization Disorder, there

should not be an additional diagnosis of **Pain Disorder Associated With Psychological Factors**, a **Sexual Dysfunction**, **Conversion Disorder**, or a **Dissociative Disorder**. **Hypochondriasis** is not be diagnosed if preoccupation with fears of having a serious illness occurs exclusively during the course of Somatization Disorder.

The criteria for Somatization Disorder in this manual are slightly more restrictive than the original criteria for **Briquet's syndrome**. Somatoform presentations that do not meet criteria for Somatization Disorder should be classified as **Undifferentiated Somatoform Disorder** if the duration of the syndrome is 6 months or longer, or **Somatoform Disorder Not Otherwise Specified** for presentations of shorter duration.

In **Factitious Disorder With Predominantly Physical Signs and Symptoms** and **Malingering**, somatic symptoms may be intentionally produced to assume the sick role or for gain, respectively. Symptoms that are intentionally produced should not count toward a diagnosis of Somatization Disorder. However, the presence of some factitious or malingered symptoms, mixed with other nonintentional symptoms, is not uncommon. In such mixed cases, both Somatization Disorder and a Factitious Disorder or Malingering should be diagnosed.

■ Diagnostic criteria for 300.81 Somatization Disorder

- A. A history of many physical complaints beginning before age 30 years that occur over a period of several years and result in treatment being sought or significant impairment in social, occupational, or other important areas of functioning.
- B. Each of the following criteria must have been met, with individual symptoms occurring at any time during the course of the disturbance:
 - (1) *four pain symptoms*: a history of pain related to at least four different sites or functions (e.g., head, abdomen, back, joints, extremities, chest, rectum, during menstruation, during sexual intercourse, or during urination)
 - (2) *two gastrointestinal symptoms*: a history of at least two gastrointestinal symptoms other than pain (e.g., nausea, bloating, vomiting other than during pregnancy, diarrhea, or intolerance of several different foods)
 - (3) *one sexual symptom*: a history of at least one sexual or reproductive symptom other than pain (e.g., sexual indifference, erectile or ejaculatory dysfunction, irregular menses, excessive menstrual bleeding, vomiting throughout pregnancy)
 - (4) *one pseudoneurological symptom*: a history of at least one symptom or deficit suggesting a neurological condition not limited to pain (conversion symptoms such as impaired coordination or balance, paralysis or localized weakness, difficulty swallowing or lump in throat, aphonia, urinary retention, hallucinations, loss of touch or pain sensation, double vision, blindness, deafness, seizures; dissociative symptoms such as amnesia; or loss of consciousness other than fainting)

(continued)

□ Diagnostic criteria for 300.81 Somatization Disorder
(continued)**C. Either (1) or (2):**

- (1) after appropriate investigation, each of the symptoms in Criterion B cannot be fully explained by a known general medical condition or the direct effects of a substance (e.g., a drug of abuse, a medication)
- (2) when there is a related general medical condition, the physical complaints or resulting social or occupational impairment are in excess of what would be expected from the history, physical examination, or laboratory findings

D. The symptoms are not intentionally produced or feigned (as in Factitious Disorder or Malingering).**300.81 Undifferentiated Somatoform Disorder*****Diagnostic Features***

The essential feature of Undifferentiated Somatoform Disorder is one or more physical complaints (Criterion A) that persist for 6 months or longer (Criterion D). The most frequent complaints are chronic fatigue, loss of appetite, or gastrointestinal or genitourinary symptoms. These symptoms cannot be fully explained by any known general medical condition or the direct effects of a substance (e.g., the effects of injury, substance use, or medication side effects), or the physical complaints or resultant impairment are grossly in excess of what would be expected from the history, physical examination, or laboratory findings (Criterion B). The symptoms must cause clinically significant distress or impairment in social, occupational, or other important areas of functioning (Criterion C). The diagnosis is not made when the symptoms are better accounted for by another mental disorder (e.g., another Somatoform Disorder, Sexual Dysfunction, Mood Disorder, Anxiety Disorder, Sleep Disorder, or Psychotic Disorder) (Criterion E). The symptoms are not intentionally produced or feigned (as in Factitious Disorder or Malingering) (Criterion F).

This is a residual category for those persistent somatoform presentations that do not meet the full criteria for Somatization Disorder or another Somatoform Disorder. Symptoms that may be seen include the examples listed for Somatization Disorder. There may be a single circumscribed symptom, such as nausea, or, more commonly, multiple physical symptoms. The chronic unexplained physical complaints often lead to medical consultation, typically with a primary care physician.

Specific Culture, Age, and Gender Features

Medically unexplained symptoms and worry about physical illness may constitute culturally shaped "idioms of distress" that are employed to express concerns about a

broad range of personal and social problems, without necessarily indicating psychopathology. The highest frequency of unexplained physical complaints occurs in young women of low socioeconomic status, but such symptoms are not limited to any age, gender, or sociocultural group. "Neurasthenia," a syndrome described frequently in many parts of the world and characterized by fatigue and weakness, is classified in DSM-IV as Undifferentiated Somatoform Disorder if symptoms have persisted for longer than 6 months.

Course

The course of individual unexplained physical complaints is unpredictable. The eventual diagnosis of a general medical condition or another mental disorder is frequent.

Differential Diagnosis

Also refer to the "Differential Diagnosis" section for Somatization Disorder (see p. 448). Undifferentiated Somatoform Disorder is differentiated from **Somatization Disorder** by the requirement in Somatization Disorder of a multiplicity of symptoms of several years' duration and an onset before age 30 years. Individuals with Somatization Disorder are typically inconsistent historians, so that at one evaluation they may report many symptoms that fulfill criteria for Somatization Disorder, whereas at another time they may report many fewer symptoms that fail to meet full criteria. If the physical complaints have persisted for less than 6 months, a diagnosis of **Somatoform Disorder Not Otherwise Specified** should be made. Undifferentiated Somatoform Disorder is not diagnosed if the symptoms are better accounted for by another mental disorder. Other mental disorders that frequently include unexplained physical complaints are **Major Depressive Disorder**, **Anxiety Disorders**, and **Adjustment Disorder**. In contrast to Undifferentiated Somatoform Disorder, the physical symptoms of **Factitious Disorders** and **Malingering** are intentionally produced or feigned. In Factitious Disorder, the motivation is to assume the sick role and to obtain medical evaluation and treatment, whereas in Malingering, more external incentives are apparent, such as financial compensation, avoidance of duty, evasion of criminal prosecution, or obtaining drugs.

■ **Diagnostic criteria for 300.81 Undifferentiated Somatoform Disorder**

- A. One or more physical complaints (e.g., fatigue, loss of appetite, gastrointestinal or urinary complaints).
- B. Either (1) or (2):
 - (1) after appropriate investigation, the symptoms cannot be fully explained by a known general medical condition or the direct effects of a substance (e.g., a drug of abuse, a medication)

(continued)

□ Diagnostic criteria for 300.81 Undifferentiated Somatoform Disorder (continued)

- (2) when there is a related general medical condition, the physical complaints or resulting social or occupational impairment is in excess of what would be expected from the history, physical examination, or laboratory findings
- C. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- D. The duration of the disturbance is at least 6 months.
- E. The disturbance is not better accounted for by another mental disorder (e.g., another Somatoform Disorder, Sexual Dysfunction, Mood Disorder, Anxiety Disorder, Sleep Disorder, or Psychotic Disorder).
- F. The symptom is not intentionally produced or feigned (as in Factitious Disorder or Malingering).

300.11 Conversion Disorder***Diagnostic Features***

The essential feature of Conversion Disorder is the presence of symptoms or deficits affecting voluntary motor or sensory function that suggest a neurological or other general medical condition (Criterion A). Psychological factors are judged to be associated with the symptom or deficit, a judgment based on the observation that the initiation or exacerbation of the symptom or deficit is preceded by conflicts or other stressors (Criterion B). The symptoms are not intentionally produced or feigned, as in Factitious Disorder or Malingering (Criterion C). Conversion Disorder is not diagnosed if the symptoms or deficits are fully explained by a neurological or other general medical condition, by the direct effects of a substance, or as a culturally sanctioned behavior or experience (Criterion D). The problem must be clinically significant as evidenced by marked distress; impairment in social, occupational, or other important areas of functioning; or the fact that it warrants medical evaluation (Criterion E). Conversion Disorder is not diagnosed if symptoms are limited to pain or sexual dysfunction, occur exclusively during the course of Somatization Disorder, or are better accounted for by another mental disorder (Criterion F).

Conversion symptoms are related to voluntary motor or sensory functioning and are thus referred to as "pseudoneurological." Motor symptoms or deficits include impaired coordination or balance, paralysis or localized weakness, aphonia, difficulty swallowing or a sensation of a lump in the throat, and urinary retention. Sensory symptoms or deficits include loss of touch or pain sensation, double vision, blindness, deafness, and hallucinations. Symptoms may also include seizures or convulsions. The more medically naive the person, the more implausible are the presenting symptoms. More sophisticated

persons tend to have more subtle symptoms and deficits that may closely simulate neurological or other general medical conditions.

A diagnosis of Conversion Disorder should be made only after a thorough medical investigation has been performed to rule out an etiological neurological or general medical condition. Because a general medical etiology for many cases of apparent Conversion Disorder can take years to become evident, the diagnosis should be viewed as tentative and provisional. In early studies, general medical etiologies were later found in from one-quarter to one-half of persons initially diagnosed with conversion symptoms. In more recent studies, misdiagnosis is less evident, perhaps reflecting increased awareness of the disorder, as well as improved knowledge and diagnostic techniques. A history of other unexplained somatic (especially conversion) or dissociative symptoms signifies a greater likelihood that an apparent conversion symptom is not due to a general medical condition, especially if criteria for Somatization Disorder have been met in the past.

Conversion symptoms typically do not conform to known anatomical pathways and physiological mechanisms, but instead follow the individual's conceptualization of a condition. A "paralysis" may involve inability to perform a particular movement or to move an entire body part, rather than a deficit corresponding to patterns of motor innervation. Conversion symptoms are often inconsistent. A "paralyzed" extremity will be moved inadvertently while dressing or when attention is directed elsewhere. If placed above the head and released, a "paralyzed" arm will briefly retain its position, then fall to the side, rather than striking the head. Unacknowledged strength in antagonistic muscles, normal muscle tone, and intact reflexes may be demonstrated. An electromyogram will be normal. Difficulty swallowing will be equal with liquids and solids. Conversion "anesthesia" of a foot or a hand may follow a so-called stocking-glove distribution with uniform (no proximal to distal gradient) loss of all sensory modalities (i.e., touch, temperature, and pain) sharply demarcated at an anatomical landmark rather than according to dermatomes. A conversion "seizure" will vary from convulsion to convulsion, and paroxysmal activity will not be evident on an EEG.

Even when following such guidelines carefully, caution must be exercised. Knowledge of anatomical and physiological mechanisms is incomplete and available methods of objective assessment have limitations. A broad range of neurological conditions may be misdiagnosed as Conversion Disorder. Prominent among them are multiple sclerosis, myasthenia gravis, and idiopathic or substance-induced dystonias. However, the presence of a neurological condition does not preclude a diagnosis of Conversion Disorder. As many as one-third of individuals with conversion symptoms have a current or prior neurological condition. Conversion Disorder may be diagnosed in the presence of a neurological or other general medical condition if the symptoms are not fully explained given the nature and severity of the neurological or other general medical condition.

Traditionally, the term *conversion* derived from the hypothesis that the individual's somatic symptom represents a symbolic resolution of an unconscious psychological conflict, reducing anxiety and serving to keep the conflict out of awareness ("primary gain"). The individual might also derive "secondary gain" from the conversion symptom—that is, external benefits are obtained or noxious duties or responsibilities are evaded. Although the DSM-IV criteria set for Conversion Disorder does not necessarily imply that the symptoms involve such constructs, it does require that psychological factors be associated with their onset or exacerbation. Because psychological factors are so ubiquitously present in relation to general medical conditions, it can be difficult to establish whether a specific psychological factor is etiologically related to the symptom or deficit. However, a close temporal relationship between a conflict or stressor and the

initiation or exacerbation of a symptom may be helpful in this determination, especially if the person has developed conversion symptoms under similar circumstances in the past.

Although the individual may derive secondary gain from the conversion symptom, unlike in Malingering or Factitious Disorder the symptoms are not intentionally produced to obtain the benefits. The determination that a symptom is not intentionally produced or feigned can also be difficult. Generally, it must be inferred from a careful evaluation of the context in which the symptom develops, especially relative to potential external rewards or the assumption of the sick role. Supplementing the person's self-report with additional sources of information (e.g., from associates or records) may be helpful.

Conversion Disorder is not diagnosed if a symptom is fully explained as a culturally sanctioned behavior or experience. For example, "visions" or "spells" that occur as part of religious rituals in which such behaviors are encouraged and expected would not justify a diagnosis of Conversion Disorder unless the symptom exceeded what is contextually expected and caused undue distress or impairment. In "epidemic hysteria," shared symptoms develop in a circumscribed group of people following "exposure" to a common precipitant. A diagnosis of Conversion Disorder should be made only if the individual experiences clinically significant distress or impairment.

Subtypes

The following subtypes are noted based on the nature of the presenting symptom or deficit:

With Motor Symptom or Deficit. This subtype includes such symptoms as impaired coordination or balance, paralysis or localized weakness, difficulty swallowing or "lump in throat," aphonia, and urinary retention.

With Sensory Symptom or Deficit. This subtype includes such symptoms as loss of touch or pain sensation, double vision, blindness, deafness, and hallucinations.

With Seizures or Convulsions. This subtype includes seizures or convulsions with voluntary motor or sensory components.

With Mixed Presentation. This subtype is used if symptoms of more than one category are evident.

Associated Features and Disorders

Associated descriptive features and mental disorders. Individuals with conversion symptoms may show *la belle indifférence* (i.e., a relative lack of concern about the nature or implications of the symptom) or may also present in a dramatic or histrionic fashion. Because these individuals are often suggestible, their symptoms may be modified or resolved based on external cues; however, it must be cautioned that this is not specific to Conversion Disorder and may also occur with general medical conditions. Symptoms may be more common following extreme psychosocial stress (e.g., warfare or the recent death of a significant figure). Dependency and the adoption of a sick role may be fostered in the course of treatment. Other nonconversion somatic complaints are common. Associated mental disorders include Dissociative Disorders, Major Depressive Disorder, and Histrionic, Antisocial, and Dependent Personality Disorders.

Associated laboratory findings. No specific laboratory abnormalities are associated with Conversion Disorder. In fact, it is the absence of expected findings that suggests and supports the diagnosis of Conversion Disorder. However, laboratory findings consistent with a general medical condition do not exclude the diagnosis of Conversion Disorder, because it only requires that a symptom not be fully explained by such a condition.

Associated physical examination findings and general medical conditions. Symptoms of Conversion Disorder typically do not conform to known anatomical pathways and physiological mechanisms. Thus, expected objective signs (e.g., reflex changes) are rarely present. However, a person may develop symptoms that resemble those observed in others or in themselves (e.g., individuals with epilepsy may simulate "seizures" that resemble those they have observed in others or how their own seizures were described to them). Generally, individual conversion symptoms are self-limited and do not lead to physical changes or disabilities. Rarely, physical changes such as atrophy and contractures may occur as a result of disuse or as sequelae to diagnostic or therapeutic procedures. It is important to note, however, that conversion symptoms can occur in individuals with neurological conditions.

Specific Culture, Age, and Gender Features

Conversion Disorder has been reported to be more common in rural populations, individuals of lower socioeconomic status, and individuals less knowledgeable about medical and psychological concepts. Higher rates of conversion symptoms are reported in developing regions, with the incidence generally declining with increasing development. Falling down with loss or alteration of consciousness is a feature of a variety of culture-specific syndromes. The form of conversion symptoms reflects local cultural ideas about acceptable and credible ways to express distress. Changes resembling conversion symptoms (as well as dissociative symptoms) are common aspects of certain culturally sanctioned religious and healing rituals. The clinician must assess whether such symptoms are fully explained in the particular social context, and whether they result in clinically significant distress, disability, or role impairment.

Conversion symptoms in children under age 10 years are usually limited to gait problems or seizures. Conversion Disorder appears to be more frequent in women than in men, with reported ratios varying from 2:1 to 10:1. Especially in women, symptoms are much more common on the left than on the right side of the body. Women (rarely men) presenting with conversion symptoms may later manifest the full picture of Somatization Disorder. Particularly in men, an association with Antisocial Personality Disorder is evident. In men, Conversion Disorder is often seen in the context of industrial accidents or the military, in which cases it must be carefully differentiated from Malingering.

Prevalence

Reported rates of Conversion Disorder have varied widely, ranging from 11/100,000 to 300/100,000 in general population samples. It has been reported as a focus of treatment in 1%-3% of outpatient referrals to mental health clinics.

Course

The onset of Conversion Disorder is generally from late childhood to early adulthood, rarely before age 10 years or after age 35 years, but onset as late as the ninth decade of life has been reported. When an apparent Conversion Disorder first develops in middle or old age, the probability of an occult neurological or other general medical condition is high. The onset of Conversion Disorder is generally acute, but gradually increasing symptomatology may also occur. Typically, individual conversion symptoms are of short duration. In individuals hospitalized with conversion symptoms, symptoms will remit within 2 weeks in most cases. Recurrence is common, occurring in from one-fifth to one-quarter of individuals within 1 year, with a single recurrence predicting future episodes. Factors that are associated with good prognosis include acute onset, presence of clearly identifiable stress at the time of onset, a short interval between onset and the institution of treatment, and above average intelligence. Symptoms of paralysis, aphonia, and blindness are associated with a good prognosis, whereas tremor and seizures are not.

Familial Pattern

Limited data suggest that conversion symptoms are more frequent in relatives of individuals with Conversion Disorder. Increased risk of Conversion Disorder in monozygotic but not in dizygotic twin pairs has been reported.

Differential Diagnosis

The major diagnostic concern in evaluating potential conversion symptoms is the exclusion of **occult neurological or other general medical conditions and substance (including medication)-induced etiologies**. Appropriate evaluation of potential general medical conditions (e.g., multiple sclerosis, myasthenia gravis) should include careful review of the current presentation, the overall medical history, neurological and general physical examinations, and appropriate laboratory studies, including investigation for use of alcohol and other substances.

Pain Disorder or a Sexual Dysfunction is diagnosed instead of Conversion Disorder if the symptoms are limited to pain or to sexual dysfunction, respectively. An additional diagnosis of Conversion Disorder should not be made if conversion symptoms occur exclusively during the course of **Somatization Disorder**. Conversion Disorder is not diagnosed if symptoms are better accounted for by **another mental disorder** (e.g., catatonic symptoms or somatic delusions in **Schizophrenia** or **other Psychotic Disorders** or **Mood Disorder** or difficulty swallowing during a **Panic Attack**). In **Hypochondriasis**, the individual is preoccupied with the "serious disease" underlying the pseudoneurological symptoms, whereas in Conversion Disorder the focus is on the presenting symptom and there may be *la belle indifférence*. In **Body Dysmorphic Disorder**, the emphasis is on a preoccupation with an imagined or slight defect in appearance, rather than a change in voluntary motor or sensory function. Conversion Disorder shares features with **Dissociative Disorders**. Both disorders involve symptoms that suggest neurological dysfunction and may also have shared antecedents. If both conversion and dissociative symptoms occur in the same individual (which is common), both diagnoses should be made.

It is controversial whether hallucinations ("pseudohallucinations") can be considered as the presenting symptom of Conversion Disorder. As distinguished from **hallucina-**

tions that occur in the context of a Psychotic Disorder (e.g., Schizophrenia or another Psychotic Disorder, a Psychotic Disorder Due to a General Medical Condition, a Substance-Related Disorder, or a Mood Disorder With Psychotic Features), hallucinations in Conversion Disorder generally occur with intact insight in the absence of other psychotic symptoms, often involve more than one sensory modality (e.g., a hallucination involving visual, auditory, and tactile components), and often have a naive, fantastic, or childish content. They are often psychologically meaningful and tend to be described by the individual as an interesting story.

Symptoms of **Factitious Disorders** and **Malingering** are intentionally produced or feigned. In Factitious Disorder, the motivation is to assume the sick role and to obtain medical evaluation and treatment, whereas more obvious goals such as financial compensation, avoidance of duty, evasion of criminal prosecution, or obtaining drugs are apparent in Malingering. Such goals may resemble "secondary gain" in conversion symptoms, with the distinguishing feature of conversion symptoms being the lack of conscious intent in the production of the symptom.

■ Diagnostic criteria for 300.11 Conversion Disorder

- A. One or more symptoms or deficits affecting voluntary motor or sensory function that suggest a neurological or other general medical condition.
- B. Psychological factors are judged to be associated with the symptom or deficit because the initiation or exacerbation of the symptom or deficit is preceded by conflicts or other stressors.
- C. The symptom or deficit is not intentionally produced or feigned (as in Factitious Disorder or Malingering).
- D. The symptom or deficit cannot, after appropriate investigation, be fully explained by a general medical condition, or by the direct effects of a substance, or as a culturally sanctioned behavior or experience.
- E. The symptom or deficit causes clinically significant distress or impairment in social, occupational, or other important areas of functioning or warrants medical evaluation.
- F. The symptom or deficit is not limited to pain or sexual dysfunction, does not occur exclusively during the course of Somatization Disorder, and is not better accounted for by another mental disorder.

Specify type of symptom or deficit:

- With Motor Symptom or Deficit**
- With Sensory Symptom or Deficit**
- With Seizures or Convulsions**
- With Mixed Presentation**

Pain Disorder

Diagnostic Features

The essential feature of Pain Disorder is pain that is the predominant focus of the clinical presentation and is of sufficient severity to warrant clinical attention (Criterion A). The pain causes significant distress or impairment in social, occupational, or other important areas of functioning (Criterion B). Psychological factors are judged to play a significant role in the onset, severity, exacerbation, or maintenance of the pain (Criterion C). The pain is not intentionally produced or feigned as in Factitious Disorder or Malingering (Criterion D). Pain Disorder is not diagnosed if the pain is better accounted for by a Mood, Anxiety, or Psychotic Disorder, or if the pain presentation meets criteria for Dyspareunia (Criterion E). Examples of impairment resulting from the pain include inability to work or attend school, frequent use of the health care system, the pain becoming a major focus of the individual's life, substantial use of medications, and relational problems such as marital discord and disruption of the family's normal lifestyle. The psychological factors involved may consist of another Axis I or Axis II disorder (which would also be diagnosed) or may be of a nature that does not reach the threshold for such a disorder (e.g., reactions to psychosocial stressors).

Subtypes and Specifiers

Pain Disorder is coded according to the subtype that best characterizes the factors involved in the etiology and maintenance of the pain:

307.80 Pain Disorder Associated With Psychological Factors. This subtype is used when psychological factors are judged to have the major role in the onset, severity, exacerbation, or maintenance of the pain. In this subtype, general medical conditions play either no role or a minimal role in the onset or maintenance of the pain. This subtype is not diagnosed if criteria for Somatization Disorder are met.

307.89 Pain Disorder Associated With Both Psychological Factors and a General Medical Condition. This subtype is used when both psychological factors and a general medical condition are judged to have important roles in the onset, severity, exacerbation, or maintenance of the pain. The anatomical site of the pain or associated general medical condition is coded on Axis III (see "Recording Procedures").

Pain Disorder Associated With a General Medical Condition. This subtype of Pain Disorder *is not considered a mental disorder and is coded on Axis III*. It is listed in this section to facilitate differential diagnosis. The pain results from a general medical condition, and psychological factors are judged to play either no role or a minimal role in the onset or maintenance of the pain. The ICD-9-CM code for this subtype is selected based on the location of the pain or the associated general medical condition if this has been established (see "Recording Procedures").

For Pain Disorder Associated With Psychological Factors and Pain Disorder Associated With Both Psychological Factors and a General Medical Condition, the following specifiers may be noted to indicate the duration of the pain:

Acute. This specifier is used if the duration of the pain is less than 6 months.
Chronic. This specifier is used if the duration of the pain is 6 months or longer.

Recording Procedures

The diagnostic code for Pain Disorder is selected based on the subtype described above. The code is 307.80 for Pain Disorder Associated With Psychological Factors. For Pain Disorder Associated With Both Psychological Factors and a General Medical Condition, 307.89 is coded on Axis I and the associated general medical condition or anatomical site of pain is coded on Axis III (e.g., 307.89 Pain Disorder Associated With Both Psychological Factors and a General Medical Condition on Axis I; 357.2 Diabetic Polyneuropathy on Axis III). For Pain Disorder Associated With a General Medical Condition, the diagnostic code for the pain is selected based on the associated general medical condition if one has been established (see Appendix G) or on the anatomical location of the pain if the underlying general medical condition is not yet clearly established—for example, low back (724.2), sciatic (724.3), pelvic (625.9), headache (784.0), facial (784.0), chest (786.50), joint (719.4), bone (733.90), abdominal (789.0), breast (611.71), renal (788.0), ear (388.70), eye (379.91), throat (784.1), tooth (525.9), and urinary (788.0).

Associated Features and Disorders

Associated descriptive features and mental disorders. Pain may severely disrupt various aspects of daily life. Unemployment, disability, and family problems are frequently encountered among individuals with chronic forms of Pain Disorder. Iatrogenic Opioid Dependence or Abuse and Benzodiazepine Dependence or Abuse may develop. Individuals whose pain is associated with severe depression and those whose pain is related to a terminal illness, most notably cancer, appear to be at increased risk for suicide. Individuals with recurrent acute or chronic pain are sometimes convinced that there is a health professional somewhere who has the “cure” for the pain. They may spend a considerable amount of time and money seeking an unattainable goal. Pain may lead to inactivity and social isolation, which in turn can lead to additional psychological problems (e.g., depression) and a reduction in physical endurance that results in fatigue and additional pain. Pain Disorder appears to be associated with other mental disorders, especially Mood and Anxiety Disorders. Chronic pain appears to be most frequently associated with Depressive Disorders, whereas acute pain appears to be more commonly associated with Anxiety Disorders. The associated mental disorders may precede the Pain Disorder (and possibly predispose the individual to it), co-occur with it, or result from it. Both the acute and chronic forms of Pain Disorder are frequently associated with insomnia.

Associated laboratory findings. In Pain Disorder Associated With Both Psychological Factors and a General Medical Condition, appropriate laboratory testing may reveal pathology that is associated with the pain (e.g., finding of a herniated lumbar disc on a magnetic resonance imaging (MRI) scan in an individual with radicular low-back pain). However, general medical conditions may also be present in the absence of objective findings. Conversely, the presence of such findings may be coincidental to the pain.

Associated physical examination findings and general medical conditions. In Pain Disorder Associated With Both Psychological Factors and a General Medical Condition, the physical examination may reveal pathology that is associated with the pain. Pain Disorder can be associated with many general medical conditions. Among the most common general medical conditions associated with pain are various musculoskeletal conditions (e.g., disc herniation, osteoporosis, osteoarthritis or rheumatoid arthritis, myofascial syndromes), neuropathies (e.g., diabetic neuropathies, post-herpetic neuralgia), and malignancies (e.g., metastatic lesions in bone, tumor infiltration of nerves). Attempts to treat the pain may lead to additional problems, some of which can cause more pain (e.g., use of nonsteroidal anti-inflammatory drugs resulting in gastrointestinal distress, surgery resulting in adhesions).

Specific Culture, Age, and Gender Features

There may be differences in how various ethnic and cultural groups respond to painful stimuli and how they express their reactions to pain. However, because there is so much individual variation, these factors are of limited usefulness in the evaluation and management of individuals with Pain Disorder.

Pain Disorder may occur at any age. Females appear to experience certain chronic pain conditions, most notably headaches and musculoskeletal pain, more often than do males.

Prevalence

Pain Disorder appears to be relatively common. For example, it is estimated that, in any given year, 10%–15% of adults in the United States have some form of work disability due to back pain alone.

Course

Most acute pain resolves in relatively short periods of time. There is a wide range of variability in the onset of chronic pain. In most cases, the symptom has persisted for many years by the time the individual comes to the attention of the mental health profession. Important factors that appear to influence recovery from Pain Disorder are the individual's participation in regularly scheduled activities (e.g., work) despite the pain and resistance to allowing the pain to become the determining factor in his or her lifestyle.

Familial Pattern

Depressive Disorders, Alcohol Dependence, and chronic pain may be more common in the first-degree biological relatives of individuals with chronic Pain Disorder.

Differential Diagnosis

Pain symptoms are included in the diagnostic criteria for **Somatization Disorder**. If the pain associated with psychological factors occurs exclusively during the course of Somatization Disorder, an additional diagnosis of Pain Disorder Associated With

Psychological Factors is not made. Similarly, if the pain presentation meets criteria for **Dyspareunia** (i.e., pain associated with sexual intercourse), an additional diagnosis of Pain Disorder is not given. Pain complaints may be prominent in individuals with **Conversion Disorder**, but by definition, Conversion Disorder is not limited to pain symptoms. Pain symptoms are common associated features of **other mental disorders** (e.g., Depressive Disorders, Anxiety Disorders, Psychotic Disorders). An additional diagnosis of Pain Disorder should be considered only if the pain is an independent focus of clinical attention, leads to clinically significant distress or impairment, and is in excess of that usually associated with the other mental disorder.

Pain symptoms may be intentionally produced or feigned in **Factitious Disorder** or **Malingering**. In Factitious Disorder, the motivation is to assume the sick role and to obtain medical evaluation and treatment, whereas more obvious goals such as financial compensation, avoidance of duties related to military service or incarceration, evasion of criminal prosecution, or obtaining drugs are apparent in Malingering.

Relationship to the Taxonomy Proposed by The International Association for the Study of Pain

The Subcommittee on Taxonomy of The International Association for the Study of Pain proposed a five-axis system for categorizing chronic pain according to I) anatomical region, II) organ system, III) temporal characteristics of pain and pattern of occurrence, IV) patient's statement of intensity and time since onset of pain, and V) etiology. This five-axis system focuses primarily on the physical manifestations of pain. It provides for comments on psychological factors on both the second axis where the involvement of a mental disorder can be coded and the fifth axis where possible etiologies include "psychophysiological" and "psychological."

■ Diagnostic criteria for Pain Disorder

- A. Pain in one or more anatomical sites is the predominant focus of the clinical presentation and is of sufficient severity to warrant clinical attention.
- B. The pain causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- C. Psychological factors are judged to have an important role in the onset, severity, exacerbation, or maintenance of the pain.
- D. The symptom or deficit is not intentionally produced or feigned (as in Factitious Disorder or Malingering).
- E. The pain is not better accounted for by a Mood, Anxiety, or Psychotic Disorder and does not meet criteria for Dyspareunia.

(continued)

□ Diagnostic criteria for Pain Disorder (continued)

Code as follows:

307.80 Pain Disorder Associated With Psychological Factors: psychological factors are judged to have the major role in the onset, severity, exacerbation, or maintenance of the pain. (If a general medical condition is present, it does not have a major role in the onset, severity, exacerbation, or maintenance of the pain.) This type of Pain Disorder is not diagnosed if criteria are also met for Somatization Disorder.

Specify if:

Acute: duration of less than 6 months

Chronic: duration of 6 months or longer

307.89 Pain Disorder Associated With Both Psychological Factors and a General Medical Condition: both psychological factors and a general medical condition are judged to have important roles in the onset, severity, exacerbation, or maintenance of the pain. The associated general medical condition or anatomical site of the pain (see below) is coded on Axis III.

Specify if:

Acute: duration of less than 6 months

Chronic: duration of 6 months or longer

Note: The following is not considered to be a mental disorder and is included here to facilitate differential diagnosis.

Pain Disorder Associated With a General Medical Condition: a general medical condition has a major role in the onset, severity, exacerbation, or maintenance of the pain. (If psychological factors are present, they are not judged to have a major role in the onset, severity, exacerbation, or maintenance of the pain.) The diagnostic code for the pain is selected based on the associated general medical condition if one has been established (see Appendix G) or on the anatomical location of the pain if the underlying general medical condition is not yet clearly established—for example, low back (724.2), sciatic (724.3), pelvic (625.9), headache (784.0), facial (784.0), chest (786.50), joint (719.4), bone (733.90), abdominal (789.0), breast (611.71), renal (788.0), ear (388.70), eye (379.91), throat (784.1), tooth (525.9), and urinary (788.0).

300.7 Hypochondriasis

Diagnostic Features

The essential feature of Hypochondriasis is preoccupation with fears of having, or the idea that one has, a serious disease based on a misinterpretation of one or more bodily signs or symptoms (Criterion A). A thorough medical evaluation does not identify a general medical condition that fully accounts for the person's concerns about disease for the physical signs or symptoms (although a coexisting general medical cond.

may be present). The unwarranted fear or idea of having a disease persists despite medical reassurance (Criterion B). However, the belief is not of delusional intensity (i.e., the person can acknowledge the possibility that he or she may be exaggerating the extent of the feared disease, or that there may be no disease at all). The belief is also not restricted to a circumscribed concern about appearance, as seen in Body Dysmorphic Disorder (Criterion C). The preoccupation with bodily symptoms causes clinically significant distress or impairment in social, occupational, or other important areas of functioning (Criterion D) and lasts for at least 6 months (Criterion E). The preoccupation is not better accounted for by Generalized Anxiety Disorder, Obsessive-Compulsive Disorder, Panic Disorder, a Major Depressive Episode, Separation Anxiety, or another Somatoform Disorder (Criterion F).

The preoccupation in Hypochondriasis may be with bodily functions (e.g., heartbeat, sweating, or peristalsis); with minor physical abnormalities (e.g., a small sore or an occasional cough); or with vague and ambiguous physical sensations (e.g., "tired heart," "aching veins"). The person attributes these symptoms or signs to the suspected disease and is very concerned with their meaning, authenticity, and etiology. The concerns may involve several body systems, at different times or simultaneously. Alternatively, there may be preoccupation with a specific organ or a single disease (e.g., fear of having cardiac disease). Repeated physical examinations, diagnostic tests, and reassurance from the physician do little to allay the concern about bodily disease or affliction. For example, an individual preoccupied with having cardiac disease will not be reassured by the repeated lack of findings on physical examination, ECG, or even cardiac angiography. Individuals with Hypochondriasis may become alarmed by reading or hearing about disease, knowing someone who becomes sick, or from observations, sensations, or occurrences within their own bodies. Concern about the feared illness often becomes a central feature of the individual's self-image, a topic of social discourse, and a response to life stresses.

Specifier

With Poor Insight. This specifier is used if, for most of the time during the current episode, the individual does not recognize that the concern about having a serious illness is excessive or unreasonable.

Associated Features and Disorders

Associated descriptive features and mental disorders. The medical history is often presented in great detail and at length in Hypochondriasis. "Doctor-shopping" and deterioration in doctor-patient relationships, with frustration and anger on both sides, are common. Individuals with this disorder often believe that they are not getting proper care and may strenuously resist referral to mental health settings. Complications may result from repeated diagnostic procedures that carry their own risks and are costly. However, because these individuals have a history of multiple complaints without a clear physical basis, they may receive cursory evaluations and the presence of a general medical condition may be missed. Social relationships become strained because the individual with Hypochondriasis is preoccupied with his or her condition and often expects special treatment and consideration. Family life may become disturbed as it becomes centered around the individual's physical well-being. There may be no effect

on functioning at work if the individual limits the hypochondriacal preoccupation to nonwork time. More often, the preoccupation interferes with performance and causes the person to miss time from work. In more severe cases, the individual with Hypochondriasis may become a complete invalid.

Serious illnesses, particularly in childhood, and past experience with disease in a family member are associated with the occurrence of Hypochondriasis. Psychosocial stressors, in particular the death of someone close to the individual, are thought to precipitate Hypochondriasis in some cases. Individuals with Hypochondriasis often have other mental disorders (particularly Anxiety and Depressive Disorders).

Associated laboratory findings. Laboratory findings do not confirm the individual's preoccupation.

Associated physical examination findings and general medical conditions. Physical examination findings do not confirm the individual's preoccupation.

Specific Culture and Gender Features

Whether it is unreasonable for the preoccupation with disease to persist despite appropriate medical evaluation and reassurance must be judged relative to the individual's cultural background and explanatory models. The diagnosis of Hypochondriasis should be made cautiously if the individual's ideas about disease have been reinforced by traditional healers who may disagree with the reassurances provided by medical evaluations. The disorder is equally common in males and in females.

Prevalence

The prevalence of Hypochondriasis in the general population is unknown. The prevalence in general medical practice has been reported to be between 4% and 9%.

Course

Hypochondriasis can begin at any age, with the most common age at onset thought to be in early adulthood. The course is usually chronic, with waxing and waning symptoms, but complete recovery sometimes occurs. It appears that acute onset, general medical comorbidity, the absence of a Personality Disorder, and the absence of secondary gain are favorable prognostic indicators. Because of its chronicity, some view this disorder as having prominent "traitlike" characteristics (i.e., a long-standing preoccupation with bodily complaints and focus on bodily symptoms).

Differential Diagnosis

The most important differential diagnostic consideration in Hypochondriasis is an underlying **general medical condition**, such as the early stages of neurological conditions (e.g., multiple sclerosis or myasthenia gravis), endocrine conditions (e.g., thyroid or parathyroid disease), diseases that affect multiple body systems (e.g., systemic lupus erythematosus), and occult malignancies. Although the presence of a general medical condition does not rule out the possibility of coexisting Hypochondriasis, transient preoccupations related to a current general medical condition do not constitute

Hypochondriasis. **Somatic symptoms** (e.g., abdominal pain) are common in children and should not be diagnosed as Hypochondriasis unless the child has a prolonged preoccupation with having a serious illness. Bodily preoccupations and fears of debility may be frequent in elderly persons. However, the onset of **health concerns in old age** is more likely to be realistic or to reflect a Mood Disorder rather than Hypochondriasis.

Hypochondriasis is diagnosed only when the individual's health concerns are not better accounted for by **Generalized Anxiety Disorder, Obsessive-Compulsive Disorder, Panic Disorder, a Major Depressive Episode, Separation Anxiety Disorder, or another Somatoform Disorder**. Individuals with Hypochondriasis may have intrusive thoughts about having a disease and also may have associated compulsive behaviors (e.g., asking for reassurances). A separate diagnosis of Obsessive-Compulsive Disorder is given only when the obsessions or compulsions are not restricted to concerns about illness (e.g., checking locks). In **Body Dysmorphic Disorder**, the concern is limited to the person's physical appearance. In contrast to a **Specific ("disease") Phobia** in which the individual is fearful of being exposed to a disease, Hypochondriasis is characterized by a preoccupation that one has the disease.

In Hypochondriasis, the disease conviction does not reach delusional proportions (i.e., the individual can entertain the possibility that the feared disease is not present), as opposed to somatic delusions that can occur in **Psychotic Disorders** (e.g., Schizophrenia, Delusional Disorder, Somatic Type, and Major Depressive Disorder, With Psychotic Features).

■ Diagnostic criteria for 300.7 Hypochondriasis

- A. Preoccupation with fears of having, or the idea that one has, a serious disease based on the person's misinterpretation of bodily symptoms.
- B. The preoccupation persists despite appropriate medical evaluation and reassurance.
- C. The belief in Criterion A is not of delusional intensity (as in Delusional Disorder, Somatic Type) and is not restricted to a circumscribed concern about appearance (as in Body Dysmorphic Disorder).
- D. The preoccupation causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- E. The duration of the disturbance is at least 6 months.
- F. The preoccupation is not better accounted for by Generalized Anxiety Disorder, Obsessive-Compulsive Disorder, Panic Disorder, a Major Depressive Episode, Separation Anxiety, or another Somatoform Disorder.

Specify if:

With Poor Insight: if, for most of the time during the current episode, the person does not recognize that the concern about having a serious illness is excessive or unreasonable

300.7 Body Dysmorphic Disorder

Diagnostic Features

The essential feature of Body Dysmorphic Disorder (historically known as dysmorphophobia) is a preoccupation with a defect in appearance (Criterion A). The defect is either imagined, or, if a slight physical anomaly is present, the individual's concern is markedly excessive (Criterion A). The preoccupation must cause significant distress or impairment in social, occupational, or other important areas of functioning (Criterion B). The preoccupation is not better accounted for by another mental disorder (e.g., dissatisfaction with body shape and size in Anorexia Nervosa) (Criterion C).

Complaints commonly involve imagined or slight flaws of the face or head such as hair thinning, acne, wrinkles, scars, vascular markings, paleness or redness of the complexion, swelling, facial asymmetry or disproportion, or excessive facial hair. Other common preoccupations include the shape, size, or some other aspect of the nose, eyes, eyelids, eyebrows, ears, mouth, lips, teeth, jaw, chin, cheeks, or head. However, any other body part may be the focus of concern (e.g., the genitals, breasts, buttocks, abdomen, arms, hands, feet, legs, hips, shoulders, spine, larger body regions, or overall body size). The preoccupation may simultaneously focus on several body parts. Although the complaint is often specific (e.g., a "crooked" lip or a "bumpy" nose), it is sometimes vague (e.g., a "falling" face or "inadequately firm" eyes). Because of embarrassment over their concerns, some individuals with Body Dysmorphic Disorder avoid describing their "defects" in detail and may instead refer only to their general ugliness.

Most individuals with this disorder experience marked distress over their supposed deformity, often describing their preoccupations as "intensely painful," "tormenting," or "devastating." Most find their preoccupations difficult to control, and they may make little or no attempt to resist them. As a result, they often spend hours a day thinking about their "defect," to the point where these thoughts may dominate their lives. Significant impairment in many areas of functioning generally occurs. Feelings of self-consciousness about their "defect" may lead to avoidance of work or public situations.

Associated Features and Disorders

Frequent mirror checking and checking of the "defect" in other available reflecting surfaces (e.g., store windows, car bumpers, watch faces) can consume many hours a day. Some individuals use special lighting or magnifying glasses to scrutinize their "defect." There may be excessive grooming behavior (e.g., excessive hair combing, hair removal, ritualized makeup application, or skin picking). Although the checking and grooming are intended by some individuals to diminish anxiety about the "defect," they often intensify the preoccupation and associated anxiety. Consequently, some individuals avoid mirrors, sometimes covering them or removing them from their environment. Others appear to alternate between periods of excessive mirror checking and avoidance. There may be frequent requests for reassurance about the "defect," but such reassurance leads to only temporary, if any, relief. Individuals with the disorder may also frequently compare their "ugly" body part with that of others. Ideas of reference related to the imagined defect are also common. Individuals with this disorder often think that others may be (or are) taking special notice of their supposed flaw, perhaps talking about it or mocking it. They may try to camouflage the "defect" (e.g., growing a beard to cover

imagined facial scars, wearing a hat to hide imagined hair loss, stuffing their shorts to enhance a "small" penis). Some individuals may be excessively preoccupied with fears that the "ugly" body part will malfunction or is extremely fragile and in constant danger of being damaged.

Avoidance of usual activities may lead to extreme social isolation. In some cases, individuals may leave their homes only at night, when they cannot be seen, or become housebound, sometimes for years. Individuals with this disorder may drop out of school, avoid job interviews, work at jobs below their capacity, or not work at all. They may have few friends, avoid dating and other social interactions, have marital difficulties, or get divorced because of their symptoms. The distress and dysfunction associated with this disorder, although variable, can lead to repeated hospitalization and to suicidal ideation, suicide attempts, and completed suicide. Individuals with Body Dysmorphic Disorder often pursue and receive general medical, dental, or surgical treatments to rectify their imagined defects. Such treatment may cause the disorder to worsen, leading to intensified or new preoccupations, which may in turn lead to further unsuccessful procedures, so that individuals may eventually possess "synthetic" noses, ears, breasts, and hips, which they are still dissatisfied with. Body Dysmorphic Disorder may be associated with Major Depressive Disorder, Delusional Disorder, Social Phobia, and Obsessive-Compulsive Disorder.

Specific Culture and Gender Features

Cultural concerns about physical appearance and the importance of proper physical self-presentation may influence or amplify preoccupations about an imagined physical deformity. Preliminary evidence suggests that Body Dysmorphic Disorder is diagnosed with approximately equal frequency in women and in men.

Prevalence

Reliable information is lacking, but Body Dysmorphic Disorder may be more common than was previously thought.

Course

Body Dysmorphic Disorder usually begins during adolescence, but may not be diagnosed for many years, often because individuals with the disorder are reluctant to reveal their symptoms. The onset may be either gradual or abrupt. The disorder often has a fairly continuous course, with few symptom-free intervals, although the intensity of symptoms may wax and wane over time. The part of the body on which concern is focused may remain the same or may change.

Differential Diagnosis

Unlike **normal concerns about appearance**, the preoccupation with appearance in Body Dysmorphic Disorder is excessively time consuming and associated with significant distress or impairment in social, occupational, or other areas of functioning. However, Body Dysmorphic Disorder may be underrecognized in settings in which cosmetic procedures are performed.

The diagnosis of Body Dysmorphic Disorder should not be made if the preoccupa-

tion is better accounted for by **another mental disorder**. Body Dysmorphic Disorder should not be diagnosed if the excessive preoccupation is restricted to concerns about "fatness" in **Anorexia Nervosa**, if the individual's preoccupation is limited to discomfort with or a sense of inappropriateness about his or her primary and secondary sex characteristics occurring in **Gender Identity Disorder**, or if the preoccupation is limited to mood-congruent ruminations involving appearance that occur exclusively during a **Major Depressive Episode**. Individuals with **Avoidant Personality Disorder** or **Social Phobia** may worry about being embarrassed by real defects in appearance, but this concern is usually not prominent, persistent, distressing, time consuming, and impairing. Although individuals with Body Dysmorphic Disorder have obsessional preoccupations about their appearance and may have associated compulsive behaviors (e.g., mirror checking), a separate diagnosis of **Obsessive-Compulsive Disorder** is given only when the obsessions or compulsions are not restricted to concerns about appearance.

Individuals with Body Dysmorphic Disorder can receive an additional diagnosis of **Delusional Disorder, Somatic Type**, if their preoccupation with an imagined defect in appearance is held with a delusional intensity.

Koro is a culture-bound syndrome that occurs primarily in Southeast Asia that may be related to Body Dysmorphic Disorder. It is characterized by the preoccupation that the penis is shrinking and will disappear into the abdomen, resulting in death. Koro differs from Body Dysmorphic Disorder by its usually brief duration, different associated features (primarily acute anxiety and fear of death), positive response to reassurance, and occasional occurrence as an epidemic.

■ **Diagnostic criteria for 300.7 Body Dysmorphic Disorder**

- A. Preoccupation with an imagined defect in appearance. If a slight physical anomaly is present, the person's concern is markedly excessive.
- B. The preoccupation causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- C. The preoccupation is not better accounted for by another mental disorder (e.g., dissatisfaction with body shape and size in **Anorexia Nervosa**).

300.81 Somatoform Disorder Not Otherwise Specified

This category includes disorders with somatoform symptoms that do not meet the criteria for any specific Somatoform Disorder. Examples include

1. **Pseudocyesis**: a false belief of being pregnant that is associated with objective signs of pregnancy, which may include abdominal enlargement (although the

umbilicus does not become everted), reduced menstrual flow, amenorrhea, subjective sensation of fetal movement, nausea, breast engorgement and secretions, and labor pains at the expected date of delivery. Endocrine changes may be present, but the syndrome cannot be explained by a general medical condition that causes endocrine changes (e.g., a hormone-secreting tumor).

2. A disorder involving nonpsychotic hypochondriacal symptoms of less than 6 months' duration.
3. A disorder involving unexplained physical complaints (e.g., fatigue or body weakness) of less than 6 months' duration that are not due to another mental disorder.

